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Division of Human Resources
Workers' Compensation
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NOTICE OF INJURY REPORT

This form is intended for internal use for all Human Resources Division/Workers' Compensation Unit user agencies and must be completed in its entirety. All Notice of Injury Reports must be electronically filed via eServices within 48 hours of an Industrial Accident. Please print clearly.

mm/dd/yyyy

E Soc. Sec. #: _____ Date of Injury: _____
M Department: _____
P Name: _____
L (First) (Middle) (Last)
O Sex: ☐ Male ☐ Female Employee ID#: _____ Record #: _____
Y Address: _____
E City: _____ State: _____ Zip: _____
E Home Telephone: _____ Date of Birth: _____ Marital Status: ☐ S ☐ M

E State Hire Date: _____ Department Hire Date: _____
M Status: ☐ Full-Time Employee ☐ Part-Time Employee Work Hours/Wk: _____
P Shift ☐ 1st ☐ 2nd ☐ 3rd Number of scheduled days off per week: _____
L Occupation: (Official Position Title) _____
O Functional Title: _____
Y Payroll Funding Source: ☐ State Payroll ☐ Trust Funded ☐ Federal Funded
E
R

I Injury Time: _____ am / pm Date Reported: _____
N Time work began on day of event: _____ am / pm
J Event occurred: ☐ Before ☐ During ☐ After Work Shift 3rd Party Claim: ☐ Yes ☐ No
U Describe how injury/illness occurred:
R What was employee doing (eg, pouring cleaning solution into a bucket):
Y _____
I How did the injury/illness occur (eg, cleaning solution splashed):
N _____
F What was the source of the injury/illness (eg, cleaning solution):
O _____

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Nature of Injury/Illness (eg, chemical burn to right eye):

Body part(s) affected (include right, left or both):

Injury Detail: Insert body part(s) and injury below from lists on pages 5 and 6.

Select Body Part(s):

Select Injury:

Select One or More Injury Categories:

- | | | |
|---|---|---|
| <input type="checkbox"/> Fall | <input type="checkbox"/> Lifting | <input type="checkbox"/> MVA (Motor Vehicle Accident) |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Exposure to Harmful Substances | <input type="checkbox"/> Repetitive Use |
| <input type="checkbox"/> Equipment | <input type="checkbox"/> Moving/Walking | <input type="checkbox"/> Stress/Heart Attack |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Cut | <input type="checkbox"/> Restraint |
| <input type="checkbox"/> Needlestick/Bloodborne Pathogen Exposure | <input type="checkbox"/> Other <input type="text"/> | |

Severity of Injury or Illness:

- ☐ (1) Minor injury; no likely lost time; no likely medical bills
☐ (2) Small injury; no likely lost time; possible medical bills
☐ (3) Moderate injury; possible lost time; probable medical bills
☐ (4) Significant injury; probably 0 – 5 days of lost time and medical bills
☐ (5) Severe injury; probably 5 plus days lost time and medical bills

Where the Injury Occurred:

Building:

Injury Location:

Example: stairwell, south walkway, office

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Was the incident the result of a violent act? ☐ Yes ☐ No

Was the claimant engaging in usual job activities? ☐ Yes ☐ No

If no, explain:

Injury reported to:
(Name, Title)

Did the Injured / Ill worker:

- | | | |
|--|------------------------------|-----------------------------|
| a. Lose consciousness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Require medical treatment more than first aid? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Have an injury from a contaminated needlestick or other sharp device? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Have a significant work-related injury/illness diagnosed by a health care professional? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Require transfer to another job or modified duty? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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If employee died as a result of injury/illness, what was the date of death? ____/____/____

Supervisor: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

Manager: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

Was the incident witnessed? ☐ Yes ☐ No

If yes, provide the names of witnesses and ask that each prepare a witness statement.

Witness: Name _____ Title _____ Phone _____

Name _____ Title _____ Phone _____

Did employee seek medical attention? ☐ Yes ☐ No

If yes, where?

a. Facility: _____

b. Address: _____

(street, town, zip code)

Did the employee seek medical attention away from the worksite?

☐ Yes ☐ No

Was the employee treated in an emergency room?

☐ Yes ☐ No

Was the employee hospitalized overnight as an in-patient?

☐ Yes ☐ No

Is employee a disabled veteran or has any other known disability?

☐ Yes ☐ No ☐ Unknown

Do you feel the employee would benefit from any referral to Rehabilitation?

☐ Yes ☐ No ☐ Unknown

Do you feel claim warrants further investigation?

☐ Yes ☐ No

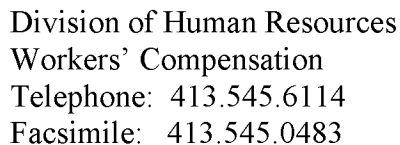
Please attach if possible any information you feel would be useful to HRD/WC Section (i.e. claimant's job description, etc.) in managing this claim.

Supervisor Signature

Please print name

Title: _____

Date _____



Body Parts List

Head	Hip/Buttocks/Groin (Buttocks)	Upper Extremities
Brain	Hip/Buttocks/Groin (Groin)	Arm(s), unspecified (Left)
Ear(s), unspecified	Hip/Buttocks/Groin (Hips)	Arm(s), unspecified (Right)
Ear(s), external	Shoulder(s) (Left)	Arm(s), unspecified (Both)
Ear(s), internal	Shoulder(s) (Right)	Arm(s), unspecified (Armpit)
Eye(s) (Left)	Shoulder(s) (Both)	Arm(s), upper (Left)
Eye(s) (Right)	Trunk, Multiple	Arm(s), upper (Right)
Eye(s) (Both)	Lower Extremities	Arm(s), upper (Both)
Face, unspecified	Leg(s), unspecified (Left)	Elbow(s) (Left)
Jaw, Chin	Leg(s), unspecified (Right)	Elbow(s) (Right)
Mouth & Throat (Lips)	Leg(s), unspecified (Both)	Elbow(s) (Both)
Mouth & Throat (Multiple)	Knee(s) (Left)	Arm(s), lower (forearm) (Left)
Mouth & Throat (Tongue)	Knee(s) (Right)	Arm(s), lower (forearm) (Right)
Mouth & Throat (Tooth/teeth)	Knee(s) (Both)	Arm(s), lower (forearm) (Both)
Mouth & Throat (Unspecified)	Leg(s), lower (e.g. calf, shin) (Left)	Arm(s), multiple (Left)
Mouth & Throat (Internal (e.g. vocal cords, larynx))	Leg(s), lower (e.g. calf, shin) (Right)	Arm(s), multiple (Right)
Nose	Leg(s), lower (e.g. calf, shin) (Both)	Arm(s), multiple (Both)
Face, multiple	Leg(s), multiple (Left)	Wrist(s) (Left)
Face (Cheeks)	Leg(s), multiple (Right)	Wrist(s) (Right)
Face (Forehead)	Leg(s), multiple (Both)	Wrist(s) (Both)
Scalp	Leg(s), upper (e.g. thigh, hamstring) (Left)	Hand(s), not wrist/fingers (Left)
Skull	Leg(s), upper (e.g. thigh, hamstring) (Right)	Hand(s), not wrist/fingers (Right)
Head, Multiple	Leg(s), upper (e.g. thigh, hamstring) (Both)	Hand(s), not wrist/fingers (Both)
Head	Ankle (Left)	Finger(s)
Neck	Ankle (Right)	Upper Extremities, multiple (Left)
Neck & cervical vertebrae	Ankle (Both)	Upper Extremities, multiple (Right)
Trunk	Foot or Feet, except ankle/toe (Left)	Upper Extremities, multiple (Both)
Trunk, UNS	Foot or Feet, except ankle/toe (Right)	Other
Abdomen, internal organs/hernia	Foot or Feet, except ankle/toe (Both)	Other (Body system)
Back	Toe(s)	Other (Multiple body parts)
Chest/Breastbone (Internal organs)	Lower Extremities, multiple (Left)	Non-Classifiable
Chest/Breastbone (Ribs, breastbone)	Lower Extremities, multiple (Right)	
	Lower Extremities, multiple (Both)	

List of Injury Types

Acute Injuries	Mental disorders
Amputation, enucleation	Mental disorders (Anxiety attacks)
Asphyxia, suffocation	Mental disorders (Other mental disorder or syndrome)
Burn, heat	Mental disorders (Stress)
Burn, chemical	Other Work-related diseases/disorders
Concussion	Other occupational disease
Contusion, crushing, bruise	Diseases of central nervous system
Cut, laceration, puncture (Except needlestick injury)	Diseases of peripheral nerves and ganglia
Cut, laceration, puncture (Needlestick/sharp injury)	Disease of the blood and blood forming organs
Cut, laceration, puncture (Splinter, chip (foreign body))	Disease of the gastro-intestinal tract
Dislocation	Carpal tunnel syndrome
Fracture	Poisoning and toxic effects
Effects of exposure to low temperature	Other poisoning due to toxic materials
Effects of environmental heat	Effects of lead
Hernia, rupture	Respiratory conditions
Effects of radiation	Other respiratory condition
Scratches, abrasion	Upper respiratory condition (e.g. allergic rhinitis)
Sprains, strains	Asthma
Multiple injuries	Asbestosis
Effects of atmospheric pressure	Silicosis
Bite/Burn/Other Injury (Bite, animal)	Influenza/Pneumonia (Influenza)
Bite/Burn/Other Injury (Bite, human)	Influenza/Pneumonia (Pneumonia)
Bite/Burn/Other Injury (Bite, insect)	Skin conditions
Bite/Burn/Other Injury (Burn, other)	Dermatitis
Bite/Burn/Other Injury (Other injury)	Infections of the skin
Electric shock/electrocution	Other skin conditions
Heart/Circulatory System Conditions	Tumor, cancer
Heart/Circulatory System (Heart condition/attack)	Tumor, unspecified
Heart/Circulatory System (High blood pressure)	Malignant Tumor
Heart/Circulatory System (Stroke or other circulatory condition)	Benign Tumor
Hearing and eye disorders	Symptoms, ill defined conditions
Hearing loss or impairment	Symptoms, ill defined conditions (Back pain, hurt back)
Conjunctivitis	Symptoms, ill defined conditions (Chest pains)
Other diseases of the eye	Symptoms, ill defined conditions (Dizziness)
Infectious or parasitic diseases	Symptoms, ill defined conditions (Headaches, migraine)
Tetanus	Symptoms, ill defined conditions (Nausea, vomiting)
Tuberculosis	Symptoms, ill defined conditions (Pain/Soreness, except back or chest)
Infectious/Parasitic Diseases (Lyme disease)	Symptoms, ill defined conditions (Sick building syndrome)
Infectious/Parasitic Diseases (Other infectious or parasitic diseases)	Symptoms, ill defined conditions (Other symptoms and ill defined conditions)
Hepatitis - viral	Other
Inflammation of the joints or tendons	No injury or illness
Joint Inflammation, etc. (Arthritis)	Damage to prosthetic devices
Joint Inflammation, etc. (Bursitis)	Non-classifiable (Exposure to saliva/body fluids)
Joint Inflammation, etc. (Other Inflammation of the joints)	Non-classifiable (Non-classifiable)
Joint Inflammation, etc. (Sciatica)	Complications peculiar to medical care
Joint Inflammation, etc. (Tendonitis)	